SEPTEMBER 11TH VICTIM COMPENSATION FUND
COMPENSATION FORM FOR PERSONAL INJURY CLAIMANTS

Compensation Form
(Parts V-X)

PART V. CLAIMANT'S MEDICAL EXPENSE LOSS OR OTHER OUT-OF-POCKET EXPENSE LOSS

A. Medical Expense or Other Expense Loss Previously Incurred

Does the Claimant seek compensation for incurred medical expenses that have not been reimbursed and that are directly related to the treatment of the condition(s) listed in Part III of the Eligibility Form? (Expenses can include rehabilitation treatment, vocational training, home modification, prescription drugs, assisted living and other such expenses.)

◯ Yes ◯ No

- If yes, what is the nature and amount of these medical expenses? Please itemize the type of medical service identified and the amount of expenses incurred for each type of medical service. You must submit documentation of any claimed medical expense loss - for example, invoices or receipts from the health provider showing payments received.

Type of Medical Expense	Amount
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
TOTAL	$, ,

Does the Claimant seek compensation for incurred other (non-medical) out-of-pocket expenses directly attributable to the Claimant's injury/condition from the September 11, 2001 terrorist attacks or debris removal?

◯ Yes ◯ No

- If no, proceed to Section B.
- If yes, please describe other out-of-pocket expense losses — i.e., expenses directly related to the condition for which the Claimant seeks compensation.

B. Future Medical Expenses

Does the Claimant seek compensation for future medical expenses directly related to the treatment of the condition(s) listed in Part III of the Eligibility Form? ◯ Yes ◯ No

- If yes, please describe anticipated future medical needs and related expenses below.

Anticipated Future Medical Needs

Anticipated Expenses

$, ,

$, ,

$, ,

$, ,

Note: Claimant will be required to submit information from a treating physician as to the Claimant's prognosis and anticipated ongoing medical treatment.

Does the Claimant seek compensation for future other (non-medical) out-of-pocket expenses directly attributable to the Claimant's injury/condition from the September 11, 2001 terrorist attacks or debris removal? ◯ Yes ◯ No

- If yes, please describe other out-of-pocket expense losses — i.e., expenses directly related to the condition for which the Claimant seeks compensation.

C. Health Insurance Information

You must complete this Section C if you are claiming past or future medical expense loss.

- Does/did the Claimant have any insurance, health care or disability benefits under which the injured Claimant is/was covered for any period in which he/she is claiming medical expenses? If yes, identify below. If the Claimant is seeking future medical expenses, please identify the Claimant's current coverage and/or eligibility in the space below.

◯ Yes ◯ No

- Please provide documentation of any reimbursement and/or coverage provided to Claimant for the condition for which the Claimant seeks compensation from the VCF. If reimbursement and/or coverage was denied by any health insurer or other benefit provider, please submit documentation of the denial.

Insurance Type

Major Medical

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

( ) -

Telephone Number

Policy Type
◯ Group ◯ Individual

Union Benefits

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

( ) -

Telephone Number

Policy Type
◯ Group ◯ Individual

Medicare

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

( ) Telephone Number

Medicaid

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

( ) Telephone Number

Disability Income Insurance

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

Telephone Number

Policy Type
◯ Group ◯ Individual

Workers' Compensation

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

Telephone Number

Other

Please Describe

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

Telephone Number

Other

Please Describe

Name of carrier

Policy or ID# if applicable

Address

Address continued

Suite

City

State

Zipcode

Telephone Number

PART VI. CLAIMANT'S LOSS OF EARNINGS TO DATE/LOSS OF REPLACEMENT SERVICES TO DATE

A. Loss of Earnings to Date

- Is the Claimant claiming loss of earnings to date as a direct result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal?

  ◯ Yes ◯ No

  - If no, proceed to Section B below.
  - If yes,
    - (1) Describe the amount of time the Claimant missed work as a result of the injury or condition (i.e. work missed for which the Claimant was not or will not be compensated).

    - (2) Describe any loss of earnings and/or other benefits from work already missed as a result of the Claimant's injury or condition (i.e. work missed for which the Claimant was not or will not be compensated). You will need to submit documentation regarding uncompensated absences from work as a result of the injury or condition sustained as a result of the September 11th air crashes or debris removal.

B. Replacement Services Loss to Date

Replacement services loss represents the loss of value of household services that the Claimant provided to the household prior to the physical injury. Please refer to the Instructions for information on whether and to what extent the VCF will consider replacement services loss in calculating economic loss.

- Does the Claimant claim any replacement services loss to date?

◯ Yes ◯ No

- If no, proceed to Part VII.
- If yes,
  - (1) Identify the specific household services that the Claimant has not been able to perform as a result of his/her injury or condition.

  - (2) If the Claimant has obtained outside assistance to perform the household services that the Claimant previously provided, please state the related costs incurred to date. You will need to submit documentation regarding any replacement services costs.

Type of Replacement Service	Amount
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
TOTAL	$, ,

PART VII. CLAIM OF LOST FUTURE EARNINGS/CLAIM OF LOST FUTURE REPLACEMENT SERVICES

A. Medical Condition — Disability

- Does the Claimant claim permanent disability or temporary disability or incapacity as a result of his/her claimed injury or condition that will result in a loss of future earnings? ◯ Yes ◯ No
  - If no, proceed to Part VIII.
  - If yes,
    - Is the disability or incapacity partial or total? Partial ◯ Total ◯
    - Is the disability or incapacity temporary or permanent? Temporary ◯ Permanent ◯
    - Has any government agency, insurer, or physician made a determination with respect to the Claimant's disability?

      ◯ Yes ◯ No
      - If yes, what entity or entities issued the determination(s)? Indicate all that apply.

        ◯ State workers' compensation board. Please specify state.

        ◯ U.S. Social Security Administration

        ◯ U.S. Department of Veterans Affairs

        ◯ U.S. Department of Labor

        ◯ State/Municpal Government Entity (e.g. FDNY). Please identify.

        ◯ Insurance company. Please identify.

        ◯ Physician. Please specify name and address.

Physician Name

Address

Address continued

Suite

City

State

Zipcode

- Please submit any determination regarding the Claimant's capacity to work in the future.

B. Loss of Future Earnings

- Does the Claimant claim a loss of future earning capacity as a result of the disability claimed above?

◯ Yes ◯ No

- If no, proceed to Section D below.
- If yes,
  - (1) Describe specifically how the Claimant's disability will affect future earning capacity, including expected duration and related compensation that will be lost.

C. Claimant's Employment History and Compensation/Benefits Information

Please complete this section only if you are seeking compensation for loss of future earnings.

Please complete the following information separately for Claimant's current employment (if currently employed) and for any previous employment (i.e., different employer or different position/job title) for the period beginning three calendar years prior to the decrease in the Claimant's earnings capacity as a result of the Claimant's disability and up to the year this claim is being filed. For example, if the Claimant was unable to continue working full-time in his or her job after May 2008, please provide history starting in 2005. If self-employed for all or part of this period, please indicate that below where asked and provide the information requested.

Note: **The VCF will need to receive documentation demonstrating the amounts and details of Claimant's compensation and benefits during this period.**

- Compensation includes base salary and wages as well as other sources of earned income such as commissions, bonuses, incentive pay, etc. Please note that passive sources of income, such as income from rental properties or investments, are not compensation for purposes of the VCF. Also note, that any compensation award for loss of future earnings will be based on certain employment benefits provided to the Claimant by his/her employer. Please see the Document Checklist and Instructions for further information.
- The Special Master recognizes that collecting this information may be a difficult task and will seek to work with the Claimant's employer to obtain and confirm information about compensation and benefits and make sure they have been calculated correctly.
- You also must submit copies of all tax return information (including W-2 forms and other attachments) for the period beginning three years prior to the decrease in the Claimant's earnings capacity as a result of the Claimant's disability and up to the year the claim is being filed.

Please submit a separate copy of pages 11 - 14 for each separate employment. Please assign a sequential job/position number (e.g., 01, 02, 03) to each set of pages in the space provided.

Please remember to submit all pages.

Employment (complete separately for each job/position)

Job/position (01, 02, 03, etc.)

Date Range: / / (mm/dd/yyyy) to / / (mm/dd/yyyy) or ◯ to present.

Job title/description:

- Please fill in the bubble that best describes your annual income (including all forms of income) *during the last year of full-time work.*

◯ Under $25,000 ◯ $100,001 - $150,000

◯ $25,000 - $50,000 ◯ $150,001 - $250,000

◯ $50,001 - $100,000 ◯ Over $250,000

◯ Indicate here if unemployed.

◯ Indicate here if employed and provide the following information:

◯ Self-employed

Employer Name

Employer Address

Employer Address continued Suite

City

State Zipcode ( ) - Employer phone number

Employer Email

Indicate how Claimant's base salary/wages are/were paid.

◯ Yearly ◯ Monthly ◯ Biweekly ◯ Weekly ◯ Hourly

◯ Other. Specify:

Job/position (01, 02, 03, etc.)

- Did Claimant receive other compensation including, but not limited to, incentive pay, bonuses, overtime, tips, commissions, shift differentials, longevity, and honoraria?

◯ Yes ◯ No

If yes, indicate any that apply:

◯ incentive pay
◯ bonuses
◯ overtime
◯ tips
◯ commissions
◯ longevity
◯ shift differentials
◯ honoraria
◯ other - describe:

Note: For Claimants who were in the armed forces - You should include information on housing, subsistence, TAD, re-enlistment, and other compensation by each category above. However, if you want the Special Master to rely on published compensation and benefit scales please check the box at the end of this statement. If you do so, there is no need to provide information on this additional compensation, but please submit a copy of the Claimant's Military Leave and Earnings Statement indicating the pay level and benefit information.

◯ I wish to rely on published data regarding U.S. military compensation.

- Did Claimant receive health benefits?

◯ Yes, throughout course of employment.

◯ Yes, for portion of employment. Please specify dates.

/ / to / /
(mm/dd/yyyy) (mm/dd/yyyy)

If yes, indicate who was covered:

◯ Claimant only

◯ Claimant and One Dependent

◯ Claimant and Family

◯ No

Job/position (01, 02, 03, etc.)

- Did employer provide pension benefits?
  - ◯ Yes, throughout course of employment.
  - ◯ Yes, for portion of employment. Please specify dates.

    (mm/dd/yyyy) to (mm/dd/yyyy)

    If yes, indicate one:
    - ◯ Defined Benefit Plan (monthly pension payable at retirement). Indicate Claimant's hire date at last employer. (mm/dd/yyyy)
    - ◯ Defined Contribution Plan (employer contribution each pay period). Indicate employer contribution as % of salary. %
  - ◯ No
- Did employer provide matching contributions to a 401(k) or 403(b)?
  - ◯ Yes, throughout course of employment.
  - ◯ Yes, for portion of employment. Please specify dates.

    (mm/dd/yyyy) to (mm/dd/yyyy)
  - ◯ No
- Did employer provide a transportation subsidy or company car?
  - ◯ Yes, throughout course of employment.
  - ◯ Yes, for portion of employment. Please specify dates.

    (mm/dd/yyyy) to (mm/dd/yyyy)

    If car was provided, please specify % of personal use: %
  - ◯ No
- Did employer provide club dues or memberships?
  - ◯ Yes, throughout course of employment.
  - ◯ Yes, for portion of employment. Please specify dates.

    (mm/dd/yyyy) to (mm/dd/yyyy)

    If yes, indicate whether:

    ◯ Yearly ◯ Monthly ◯ Biweekly ◯ Weekly ◯ Hourly

    ◯ Other. Specify:
  - ◯ No

Job/position (01, 02, 03, etc.)

- Did employer provide a housing allowance (Non-military) (military allowances should be included on page 12)?

◯ Yes, throughout course of employment.

◯ Yes, for portion of employment. Please specify dates.

(mm/dd/yyyy) to (mm/dd/yyyy)

If yes, indicate whether the allowance was:

◯ Yearly ◯ Monthly ◯ Biweekly ◯ Weekly ◯ Hourly

◯ Other. Specify:

Indicate whether the allowance was:

◯ Permanent.

◯ Temporary. If temporary, when did it end? (mm/dd/yyyy)

◯ No

- Did employer provide other benefits?

◯ Yes, throughout course of employment.

◯ Yes, for portion of employment. Please specify dates.

(mm/dd/yyyy) to (mm/dd/yyyy)

If yes, describe:

Indicate whether the benefit was:

◯ Yearly ◯ Monthly ◯ Biweekly ◯ Weekly ◯ Hourly

◯ Other. Specify:

◯ No

D. Loss of Future Replacement Services

Replacement services loss represents the loss of value of household services that the Claimant provided to the household prior to the physical injury or condition. Please refer to the Instructions for more information on whether and to what extent the VCF will consider replacement services loss in calculating economic loss.

- Does the Claimant claim any future household services that the Claimant will be unable to perform as a result of the injury? ◯ Yes ◯ No
  - If no, proceed to Part VIII.
  - If yes,
    - (1) Identify the specific household services that the Claimant will not be able to perform as a result of his/her injury or condition.

- (2) Describe the value (on an hourly, monthly or annual basis) of replacement services that the Claimant will need to obtain in order to perform those tasks that the Claimant previously performed but can no longer perform as a result of his/her injury or condition.

Type of Replacement Service	Amount	Basis
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual
	$, ,	◯ Hourly ◯ Monthly ◯ Annual

PART VIII. COLLATERAL SOURCE PAYMENTS

In this Part, please identify any compensation or benefits the Claimant received or is entitled to receive from other sources as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. For example, if the Claimant has received insurance or a specific payment from an employer that is not part of the normal compensation, these might be considered "collateral source" payments. Under the Act, the Special Master is required to reduce the compensation award by the amount of collateral source compensation a Claimant has received or is entitled to receive as a result of the terrorist-related aircraft crashes of September 11, 2001 or debris removal efforts. Note: Settlement payments from September 11th-related lawsuits are to be included in Part I.E. and do not need to be listed again in this Part.

A. Social Security and Workers' Compensation Programs

Has the Claimant applied to receive any payments from the Social Security Administration or from workers' compensation programs as a result of the Claimant's injury? (Include uniformed service benefits similar to Social Security or workers' compensation). ◯ Yes ◯ No

- If yes, please identify the program(s) or benefit(s) applied for and the status.

Program or Benefit	Application Status: Approved	Denied	Pending
	◯	◯	◯
	◯	◯	◯
	◯	◯	◯

Please submit any pending applications.

- For any application approved, please identify and describe any payments that the Claimant has received or is receiving and submit rulings, orders, determinations, or correspondence from the Social Security Administration or workers' compensation program.

Payment Description - include time period when payments were received and if payments are ongoing.	Amount	Basis
	$, ,	◯ Weekly ◯ Annual ◯ Monthly ◯ Other
	$, ,	◯ Weekly ◯ Annual ◯ Monthly ◯ Other
	$, ,	◯ Weekly ◯ Annual ◯ Monthly ◯ Other
	$, ,	◯ Weekly ◯ Annual ◯ Monthly ◯ Other

B. Other Payments

Has the Claimant received any other payments as compensation for or in response to the Claimant's injury (excluding charitable contributions)?

◯ Yes ◯ No

If yes, please identify and describe and submit any documentation of such payments.

Type of Payment	Amount of Payment
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
	$, ,
TOTAL	$, ,

PART IX. OTHER INFORMATION (OPTIONAL)

Please use the area below (and any additional pages) to provide any other information that you believe may be relevant to the individualized circumstances of your claim and the calculation of the economic and non-economic loss as well as collateral offsets. You may also submit any additional documents not already requested that you believe might be relevant.

PART X. CERTIFICATION FOR COMPENSATION FORM

A. Privacy Act Notice

The U.S. Department of Justice is authorized to collect this information by the September 11th Victim Compensation Fund of 2001, Title IV of Public Law 107-42, Air Transportation Safety and System Stabilization Act, 49 U.S.C. § 40101 note, as amended by the James Zadroga 9/11 Health and Compensation Act of 2010, Title II of Public Law 111-347. The information you submit in your claim is for official use by the U.S. Department of Justice for the purposes of determining your eligibility for and the amount of compensation you may receive under your claim to the Victim Compensation Fund. Provision of this information is voluntary; however, failure to provide complete information may result in a delay in processing or a denial of your claim. Information you submit regarding your claim may be disclosed by the Government only in accordance with the provisions of the Privacy Act.

I Authorize the U.S. Department of Justice to disclose any records or information relating to my Victim Compensation Fund claim for the purpose of determining qualification and/or compensation of my claim to: agency contractors assisting in the administration of the Victim Compensation Fund; other federal, state, or local agencies, including the U.S. Department of Treasury and NIOSH; and other individuals or entities having information related to the claim, such as physicians, medical service providers, insurers, and employers.

Signature of Claimant or Authorized Representative (e.g. legal guardian)

Date (mm/dd/yyyy)

If not Claimant:

Print Name

Relationship to Claimant

B. Certification of Accuracy of Information

I hereby certify that the information provided in this application and any documents provided in support of this claim are true and accurate to the best of my knowledge, and I agree that any payment made by the VCF is expressly conditioned upon the truthfulness and accuracy of the information and documentation provided in support of the claim. Further, I understand that false statements or claims made in connection with this application may result in fines, imprisonment and/or any other remedy available by law to the Federal Government, and that suspicious claims will be forwarded to federal, state, and local law enforcement authorities for possible investigation and prosecution.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this ____ day of _____, 201____ .

_____
Signature of Claimant or Authorized Representative (e.g. legal guardian)

If not Claimant:

_____ _____
Print Name Relationship to Claimant

C. Paperwork Reduction Act Notice

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it contains a currently valid OMB approval number. We try to create forms and instructions that are accurate, can be easily understood, and that impose the least possible burden on you. The estimated average time to complete and file this application is 8.5 hours. If you have comments regarding the accuracy of this estimate, or suggestions for making this form simpler, you can write to the Office of the Special Master, U.S. Department of Justice, 950 Pennsylvania Ave, NW, Washington, DC 20530; OMB control number 1105-0092. (Do not mail your completed application to this address.)

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

In order to process your claim, we need certain supporting documents. This checklist will help you compile those documents. Please categorize your documents by the section of the claim form for which they are being submitted. If you have no documents to submit for a particular section, mark the bubble in the "Submission Complete or No Documents to Submit" column for that section. You are strongly encouraged to upload your documents electronically, which will allow a more efficient claims process. If you are submitting a hard copy claim form and would like to upload documents electronically, you will need to register at www.VCF.gov. Once your hard copy claim form is received, processed, and loaded to the electronic system, you will have the ability to upload documents. If you do not have access to electronic copies of documents or do not wish to register at www.VCF.gov, you may submit hard copies of those documents by mail. To do so, mark the appropriate bubbles in the "Mailed" column for each section that you are submitting. Then send the documents along with a copy of this form, by mail to September 11th Victim Compensation Fund; P.O. Box 34500; Washington, DC 20043. The Claimant's Social Security Number or National ID Number should be written on the top of all documents submitted by mail. For your records, you should keep a copy of all documents submitted by mail to the VCF.

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part V. Claimant's Medical Expense Loss Or Other Out-Of-Pocket Expense Loss (If Applicable)		○
A. Medical or Other Expenses Previously Incurred Please submit written proof of any claimed medical or other expenses that were not reimbursed - for example, invoices or receipts for prescription drugs, rehabilitation treatment, or from the health provider showing payments received.	○	
B. Future Medical or Other Expenses Please provide any documentation that you believe is relevant to a determination of your claim for future medical or other expenses. If you seek future medical expenses, you must submit a statement from a treating physician regarding your prognosis and need for ongoing treatment. You may also submit other documents, such as documentation of current and/or expected expenses.	○	
C. Health Insurance Information Documentation of your health insurance coverage for any period in which you are claiming past medical expenses. If you are claiming future medical expenses, please provide documentation of your current health insurance coverage. You do not need to provide documentation of your health insurance coverage if you are not seeking compensation for medical expense loss.	○	

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part VI. Claimant's Loss of Earnings to Date / Loss of Replacement Services to Date		○
A. Compensation Information (base/salary/wages) (if applicable) Documentation of loss of prior earnings and/or other benefits from work already missed as a result of your injury (number of days that were not reimbursed and related compensation lost). The documentation should demonstrate how many days of work were missed and the corresponding loss of compensation and/or benefits. Examples of such documents include: (1) Pay stubs (2) Salary letters (3) End of year pay statement (4) Sworn and notarized affidavit (or unsworn statement complying with 28 U.S.C. 1746) from your employer describing the work missed and loss of earnings	○	
B. Replacement Service Loss to Date (if applicable) Documentation of type and costs of replacement services to date (e.g., invoices or receipts showing services rendered and payments received).	○	

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part VII. Claim of Lost Future Earnings/Claim of Lost Future Replacement Services **You should submit this information only if you are seeking compensation for loss of future earnings and/or loss of future replacement services.**		◯
A. Medical Condition — Disability If any government agency, insurer, or physician has made a determination with respect to your disability, please submit documentation related to that determination. If such a determination has not been made, submit other documentation regarding your disability and/or capacity to work in the future, such as evaluations or reports from doctors or medical experts.	◯	
C. Compensation/Benefits Information (for Claims of Loss of Future Earnings) (If applicable) To demonstrate anticipated future loss of earnings (compensation that will be lost due to disability resulting from claimed injury or condition), please attach written proof of your compensation, including benefits and any other form of compensation, as well as pension information, for the period beginning three calendar years prior to the decrease in your earnings capacity as a result of your disability and up to the year this claim is being filed. Examples of the types of proof to include are: (1) Pay stubs (2) Salary letters (3) End of year pay statement (4) Bonus letters (5) End of the year benefit statements (6) 401(k) statements (7) Pension plan descriptions and statements (8) Documentation on health benefits (9) Documentation demonstrating other employer-provided benefits such as transportation, club dues, or housing allowance.	◯	
You **must** also submit copies of all tax return information (including W-2 forms and other attachments) for the period beginning three years prior to the decrease in your earnings capacity as a result of your disability and up to the year claim is being filed, including returns for non-U.S. taxing authorities.	◯	
D. Future Loss of Replacement Services (if applicable) Documentation of type and costs of replacement services expected to be incurred in the future (e.g., invoices or receipts showing prior services rendered and payments received, or estimates or price quotes for future services).	◯	

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part VIII. Collateral Source Compensation Please submit documentation of all collateral sources of compensation you have received or are entitled to receive. Examples of collateral sources of compensation are listed below. Please check the ones that apply and for which you have submitted documentation.		◯
Social Security application or determination or related correspondence	◯	
Workers' Compensation application or determination or related correspondence	◯	
Short-term disability insurance	◯	
Long-term disability insurance	◯	
Other (please describe)	◯	
Other (please describe)	◯	

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part IX. Other Information in Support of Compensation Form (optional) Please list any additional documents that you have included that you believe may be relevant to the individualized circumstances of your claim and the calculation of the economic and non-economic loss as well as collateral offsets.		○
Other (please describe)	○	
Other (please describe)	○	
Other (please describe)	○	

COMPENSATION FORM SUPPORTING DOCUMENTATION CHECKLIST — PERSONAL INJURY CLAIMANTS

Supporting Documentation for Compensation Form: Parts V-X	Mailed	Submission Complete / No Documents to Submit
Part X. Certification for Compensation Form		◯
Please sign the Privacy Act Notice and the Certification of Accuracy of Information, and mail all pages of Part X (including pages without your signature) to the VCF at September 11th Victim Compensation Fund; P.O. Box 34500; Washington, DC 20043. **You must mail pages with your original signature (no copies)**, but you should keep a copy for your own records. If possible, please also upload copies of the signed pages so that the VCF can begin processing your claim.	◯	
Exhibits		
If you are claiming a disability or a loss of prior or future earnings, you **must** submit Compensation Exhibit 1. **You must mail pages with your original signature (no copies)**, but you should keep a copy for your own records. If possible, please also upload copies of the signed pages so that the VCF can begin processing your claim.	◯	
If you have identified any medical providers, New York pension funds, or other entities in the Compensation Form that may have medical or pension information relevant to your claim but that were not identified in the Eligibility Form, please submit additional copies of Exhibit A, Exhibit B1, and Exhibit B2 as appropriate for those individuals and entities. **You must mail pages with your original signature (no copies)**, but you should keep a copy for your own records. If possible, please also upload copies of the signed pages so that the VCF can begin processing your claim.	◯	